Medicare Regulations: Skilled Wound Care

Colleen Bayard PT, MPA, COS-C
Director of Regulatory and Clinical Affairs
Home Care Alliance of MA
PART 484 -- HOME HEALTH SERVICES

Sections 1861(o) and 1891 SS Act, establish conditions HHA must meet to participate in the Medicare program and additional requirements considered necessary to ensure the health/safety of patients.

Medicare home health services are covered for eligible patients by a Medicare certified home health agency (HHA).

Section 1861(m) describes home health services
Medicare: Conditions of Coverage

For Home Health Care to be covered:

- Reasonable and Necessary (Requires skilled care)
- Patient must be homebound
  - Patient’s Place of Residence
- Services under a Plan of Care established and approved by physician.
  - Signs the POC (timely signature)
  - At least every 60 days, more often as needed
- Face to Face Encounter
Individual considered “confined to the home” (homebound) if following two criteria are met:

Criteria-One: The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
  OR
- Have a condition such that leaving his or her home is medically contraindicated.

Criteria-Two: Both must be met:

- There must exist a normal inability to leave home;
  AND
- Leaving home must require a considerable and taxing effort.
40.1.3 - Intermittent Skilled Nursing Care

- The law, at §1861(m) of SS Act defines intermittent as skilled nursing care:
  - That is either provided or needed 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.)

- To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

- The EXCEPTION:
  - The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).
Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.
40.1.2.8 - Wound Care

For skilled nursing care to be reasonable and necessary to treat a wound:

- the size,
- depth,
- nature of drainage (color, odor, consistency, and quantity), and
- condition and appearance of the skin surrounding the wound

Must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made.

Plan of care must contain the specific instructions for wound treatment.
40.1.2.8 - Wound Care

Per Medicare Manual - Chapter 7

Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;

- Wounds with a drain or T-tube with requires shortening or movement of such drains;

- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
40.1.2.8 - Wound Care

- Recently debrided ulcers;

- Pressure sores (decubitus ulcers) with the following characteristics:
  - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or
  - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

**NOTE:** Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);

- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
40.1.2.8 - Wound Care

- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);

- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;

- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;

- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.
Patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services.

However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services.

Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.
Patient Notices

Home Health Care of Care Notice- HHCCN
Advanced Beneficiary Notice- ABN
Notice of Medicare Non-coverage -NOMNC
§ 484.50 COP: Patient rights

§ 484.50(c)(8). Standard: Rights of the patient.

The patient has the right to—

- Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that
  - the service may be non-covered care; or
  - in advance of the HHA reducing or terminating on-going care.
HHA must provide HHCCN:
- Reducing or terminating a HH service or item.
- Decreasing the frequency of care at recertification

Triggering Event Due to Physician Order
- Reduction: POC lists wound care as daily, new order for every other day
- Termination: POC- wound care 2x wk provider writes new order to discharge SN and wound care (PT still involved in case)
HHCCN

Home Health Agency:  Patient Name:
Address:  Patient Identification:
Phone:

Home Health Change of Care Notice (HHCCN)
Your home health care is going to change. Starting on __/__/____, your home health agency will change the following items and/or services for the reasons listed below:

<table>
<thead>
<tr>
<th>Items/services:</th>
<th>Reason for change:</th>
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Read the information next to the checked box below. Your home health agency is giving you this information because:

- [ ] Your doctor’s orders for your home care have changed.
  - The home health agency must follow physician orders to give you care.
  - The home health agency can’t give you home care without a physician’s order.
  - If you don’t agree with this change, discuss it with your home health agency or the doctor who orders your home care.

- [ ] Your home health agency has decided to stop giving you the home care listed above.
  - You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
  - If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.
  - If you get care from a different home health agency, you can ask it to bill Medicare.

If you have questions about these changes, you can contact your home health agency and/or the doctor who orders your home care.

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

Additional Information:

Please sign and date below to show that you received and understand this notice. Return this signed notice to your home health agency in person or by mailing it to them at the address listed at the top of this notice.

Signature of the Patient or of the Authorized Representative  Date

*If a representative signs for the beneficiary, write “(rep)” or “(representative)” next to the signature. If the representative’s signature is not clearly legible, the representative’s name must be printed.

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Form CMS-10280 (Approved 06/2016)  OMB Approval No. 0938-1196
Notice of Medicare Non-Coverage

NOMNC

- HHAs required to provide Notice of Medicare Non-Coverage (NOMNC) to patient when Medicare covered service(s) are ending.

- NOMNC informs patient how to request an expedited determination from their Quality Improvement Organization (QIO).

- A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of services, and is completed by the provider.
Notice of Medicare Non-Coverage – NOMNC

[Insert provider contact information here]

Notice of Medicare Non-Coverage

Patient name: ____________________________ Patient number: ____________________________

The Effective Date Coverage of Your Current [insert type] Services Will End [insert effective date]

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current [insert type] services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision:
- You have the right to an immediate, independent medical review ( appeal ) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent review will ask for your opinion. The reviewer also will look at your medical records and other relevant information. You do not have to prepare anything in writing, but if you choose, you are welcome to do so.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above:
  - Medicare will not pay for these services after that date.
  - If you stop service no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal:
- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- If you have questions, call your QIO at [insert QIO name and toll-free number of QIO] to appeal, or if you have questions, see page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:
- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: ____________________________

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative: ____________________________ Date: ____________________________

Form CMS 15020(NOMNC) (Approved 12/11/2011) CMS approval 01/08-0853
Notice of Medicare Non-Coverage NOMNC

- Written advance notice of intent to discharge patient from all home health services under Medicare
  - Give minimum of 2 days in advance or
  - Second to last visit if there will be extended time between visits and includes:
    - Date coverage ends,
    - Right to an expedited determination and
    - How the patient can exercise the right to appeal
When is a NOMNC Form Required?

- Complete cessation of Medicare coverage
  - Treatments are no longer medically necessary
  - Teaching has been completed
  - Medical condition has stabilized
  - Homebound requirement is no longer met
  - Physicians orders are terminated
  - Goals of care have been attained
Notice of Medicare Non-Coverage
Patient’s Appeal

How does the patient appeal the discharge?

- Patient (or representative) has until noon on day after notice of discharge to request expedited review.
- Review is completed by Livanta
  - Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Responsible for medical case review, supporting the rights of Medicare patient

Livanta
https://bfccqioarea1.com/bfccqio.html
What the Provider needs to do....

**Detailed Explanation of Provider Non-coverage (DENC)**

- **Provider completes by the close of the day after patient requests** an expedited determination from the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO)
- The DENC needs:
  - specific, detailed information why services are no longer considered reasonable & necessary or otherwise covered by Medicare;
  - description of applicable Medicare coverage rules;
  - any specific beneficiary applicable information relevant to the coverage determination.

- Who would complete this in your agency?
Detailed Explanation of Non-Coverage

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: _______________  Patient number: _______________

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. This notice is not the decision on your appeal. The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current [insert type] services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: (insert provider/plan toll-free telephone number)
Notice of Medicare Non-Coverage Patient’s Appeal

Patient Appeal Process:

- BFCC-QIO has 72 hrs from request to render decision & notify patient, provider and MD responsible for care.
- Patient may request expedited reconsideration by Quality Improvement Contractor (QIC) if disagrees with Livanta’s decision.
- Provider cannot bill patient for services until after patient receives decisions from Livanta and/or QIC.
- If QIC does not make a decision within 72 hours, beneficiary may request case escalated to ALJ review.
Advance Beneficiary Notice-ABN

Form CMS-R-131
Issued by HHA to patients in situations where Medicare payment is expected to be denied.
Advance Beneficiary Notice of Noncoverage (ABN)

A. Notifier: 
B. Patient Name: 
C. Identification Number: 

NOTE: If Medicare doesn’t pay for D. ______ listed below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. ______ listed below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay:</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
</table>

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. ______ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. ______ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D. ______ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D. ______ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:  
J. Date:  

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According to the Department Reorganization Act of 1995, no person is required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Att’n OIRA, Report Clearance Officer, Baltimore, Maryland 21244-6500.
Advanced Beneficiary Notice- ABN

- Always used for potential financial liability
  - Signed-prior to providing care
- Used when services are usually covered by Medicare but in this instance may not be covered.
  - The care is not medically reasonable and necessary,
  - The beneficiary is not confined to his/her home,
  - The beneficiary does not need skilled nursing care on an intermittent basis, or
  - The beneficiary is receiving custodial care only.
### Reasons HH is Not Covered

<table>
<thead>
<tr>
<th>Description of Situation</th>
<th>Recommended Explanation for Reason Medicare May Not Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care is not reasonable and necessary</td>
<td><em>Medicare does not pay for care that is not medically reasonable and necessary</em></td>
</tr>
<tr>
<td>Custodial care is the only care delivered</td>
<td><em>Medicare does not usually pay for custodial care, except for some hospice services</em></td>
</tr>
<tr>
<td>Beneficiary is not homebound</td>
<td><em>Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit</em></td>
</tr>
<tr>
<td>Beneficiary does not need skilled nursing care on an intermittent basis</td>
<td><em>Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit</em></td>
</tr>
</tbody>
</table>
Option Boxes

- The patient or representative must choose only one of the three options listed in Blank (G) form CMR-R-131.
- Under no circumstances can the HHA staff decide for the beneficiary which of the 3 checkboxes to select.
- Pre-selection of an option by the HHA invalidates the notice.
- However, at the beneficiary’s request, HHA may enter the beneficiary’s selection if he or she is physically unable to do so.
  - In such cases, HHA must annotate the notice accordingly.
**Option 1: Indicates the Choice to Bill Medicare**

- **OPTION 1.** I want the _______ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- Beneficiaries select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by a secondary insurer or if the patient wants “Demand Billing”.
Option 2 - Used for Dually Eligible

☐ OPTION 2. I want the _____ _____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket.
- No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

MA Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, therefore the patient should choose Option 2.
Option 2

- **HHAs may direct dual eligibles on choosing the correct option box according to State directives.**

- **HHAs are permitted to pre-type information in the “Additional Information” area for ABNs issued to dual eligibles to help them understand that Medicaid will pay for the service.**

- **When Option 2 is chosen based on State guidance, HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, - the HHA must add a statement in the “Additional Information” box such as:**

  “Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan.”
Option 3- Patient Doesn’t Want the Care

☐ OPTION 3. I don’t want the _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.
GOT A Question?
Medicare Benefit Policy Manual Chapter 7 - Home Health Services


Conditions of Participation (COP)


Resources
Resources

Medicare Benefit Policy Manual Chapter 7 - Home Health Services


Conditions of Participation (COP)

Resources
(handouts)

Notice of Medicare Non-coverage-NOMNC

Home Health Change of Care Notice- HHCCN
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHCCN.html

Advance Beneficiary Notice
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html